FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039834

Facility Name: Jackson Square Nrsg & Rehab Ctr

Address: 5130 West Jackson Boulevard (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

HFS ID Number: 363961688001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	66,167	219	8,635	75,021	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,167	219	8,635	75,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.84%

D. How many bed-hold days during this year were paid by the Department?
1,717 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 0701/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [X] If YES, enter number of beds certified 66 and days of care provided 7,074

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	294,095	107,120	11,520	412,735		412,735	(34)	412,701			1
2	Food Purchase		335,099		335,099	(16,983)	318,116	(10)	318,106			2
3	Housekeeping		35,399	366,340	401,739		401,739		401,739			3
4	Laundry		23,319		23,319		23,319		23,319			4
5	Heat and Other Utilities			337,079	337,079		337,079	(8,188)	328,891			5
6	Maintenance	94,566	25,479	155,063	275,108		275,108	4,258	279,366			6
7	Other (specify):*											7
8	TOTAL General Services	388,661	526,416	870,002	1,785,079	(16,983)	1,768,096	(3,974)	1,764,122			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,897,589	225,767	66,445	3,189,801		3,189,801	(18,112)	3,171,689			10
10a	Therapy	10,080		2,677	12,757		12,757		12,757			10a
11	Activities	90,101	9,293	1,370	100,764		100,764		100,764			11
12	Social Services	111,574		1,170	112,744		112,744		112,744			12
13	CNA Training											13
14	Program Transportation			725	725		725		725			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,109,344	235,060	93,987	3,438,391		3,438,391	(18,112)	3,420,279			16
	C. General Administration											
17	Administrative	110,954		779,422	890,376		890,376	(739,474)	150,902			17
18	Directors Fees											18
19	Professional Services			92,512	92,512	(5,841)	86,671	(5,697)	80,974			19
20	Dues, Fees, Subscriptions & Promotions			149,437	149,437		149,437	(82,751)	66,686			20
21	Clerical & General Office Expenses	213,357	38,877	196,976	449,210		449,210	5,554	454,764			21
22	Employee Benefits & Payroll Taxes			627,866	627,866	16,983	644,849	(2,000)	642,849			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,661	13,661		13,661	(798)	12,863			24
25	Other Admin. Staff Transportation			4,434	4,434		4,434	418	4,852			25
26	Insurance-Prop.Liab.Malpractice			495,134	495,134		495,134	13,118	508,252			26
27	Other (specify):*							31,083	31,083			27
28	TOTAL General Administration	324,311	38,877	2,359,442	2,722,630	11,142	2,733,772	(780,547)	1,953,225			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,822,316	800,353	3,323,431	7,946,100	(5,841)	7,940,259	(802,633)	7,137,626			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr #0039834 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			165,915	165,915		165,915	135,436	301,351			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,335	63,335		63,335	664,419	727,754			32
33	Real Estate Taxes			(5,967)	(5,967)	5,841	(126)	292,901	292,775			33
34	Rent-Facility & Grounds			1,871,652	1,871,652		1,871,652	(1,871,652)				34
35	Rent-Equipment & Vehicles			10,426	10,426		10,426	3,566	13,992			35
36	Other (specify):*							125,001	125,001			36
37	**TOTAL Ownership**			2,105,361	2,105,361	5,841	2,111,202	(650,329)	1,460,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	3,880	85,677	742,329	831,886		831,886	(357)	831,529			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*	68,809			68,809		68,809	(68,809)				43
44	**TOTAL Special Cost Centers**	72,689	85,677	870,444	1,028,810		1,028,810	(69,166)	959,644			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,895,005	886,030	6,299,236	11,080,271		11,080,271	(1,522,128)	9,558,143			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(77,001)	30		9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(600)	20		18
19	Entertainment	(1,453)	24		19
20	Contributions	(16,730)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	21		24
25	Fund Raising, Advertising and Promotional	(64,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(284)	20		28
29	Other-Attach Schedule	(200,120)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (456,275)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,065,853)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,065,853)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,522,128)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Jackson Square Nrsg & Rehab Ctr

ID# 0039834

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pharmacy - Veterans	$ (736)	10	1
2	Medical Expense - Veterans	(508)	10	2
3	Enteral Feeding - Veterans	(34)	01	3
4	Wound Care - Veterans	(357)	39	4
5	Bank Charges	(17,252)	21	5
6	Patient Clothing	(3,883)	10	6
7	Seminar	(3,928)	21	7
8	Patient Needs	(12,913)	10	8
9	COPE Dues	(3,008)	20	9
10	Unallowable Legal Fee - Prior year	(732)	19	10
11	Part B Coins W/O-OT	(15,091)	21	11
12	Part B Coins W/O-PT	(12,126)	21	12
13	Part B Coins W/O-ST	(11,769)	21	13
14	Non-Allowable Office	(3,266)	21	14
15	Employee Benefits Expense	(2,000)	22	15
16	Non-Allowable Emp Bene - Nucare	(189)	27	16
17	Marketing	(4,078)	19	17
18	Non-Allowable Salaries	(68,809)	43	18
19	Prior Year Legal	(1,373)	19	19
20	Settlement Expense	(2,500)	19	20
21	Network Fees	(500)	19	21
22	Clinic Allocation - Utilities	(11,266)	05	22
23	Clinic Allocation - RE Taxes	(23,738)	33	23
24				24
25				25
26				26
27				27
28				28
29				29
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100				100
101	**Total**	(200,120)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr **#** 0039834 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(34)											(34)	1
2	Food Purchase	(10)											(10)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,266)		3,078									(8,188)	5
6	Maintenance			4,258									4,258	6
7	Other (specify):*													7
8	**TOTAL General Services**	(11,310)		7,336									(3,974)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(18,112)											(18,112)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(18,112)											(18,112)	16
	C. General Administration													
17	Administrative			(739,474)									(739,474)	17
18	Directors Fees													18
19	Professional Services	(9,183)		3,486									(5,697)	19
20	Fees, Subscriptions & Promotions	(84,676)		1,925									(82,751)	20
21	Clerical & General Office Expenses	(159,432)		164,986									5,554	21
22	Employee Benefits & Payroll Taxes	(2,000)											(2,000)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,453)		655									(798)	24
25	Other Admin. Staff Transportation			418									418	25
26	Insurance-Prop.Liab.Malpractice		7,286	5,832									13,118	26
27	Other (specify):*	(189)		31,272									31,083	27
28	**TOTAL General Administration**	(256,933)	7,286	(530,900)									(780,547)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(286,355)	7,286	(523,564)									(802,633)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr **#** 0039834 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**(77,001)**	**202,928**	**9,509**									**135,436**	**30**
31	Amortization of Pre-Op. & Org.													**31**
32	Interest	**(15)**	**663,132**	**1,302**									**664,419**	**32**
33	Real Estate Taxes	**(23,738)**	**314,054**	**2,585**									**292,901**	**33**
34	Rent-Facility & Grounds		**(1,872,167)**	**515**									**(1,871,652)**	**34**
35	Rent-Equipment & Vehicles			**3,566**									**3,566**	**35**
36	Other (specify):*		**125,001**										**125,001**	**36**
37	**TOTAL Ownership**	**(100,754)**	**(567,052)**	**17,477**									**(650,329)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers	**(357)**											**(357)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*	**(68,809)**											**(68,809)**	**43**
44	**TOTAL Special Cost Centers**	**(69,166)**											**(69,166)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(456,275)**	**(559,766)**	**(506,087)**									**(1,522,128)**	**45**

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,872,167	Jackson Square Associates	100.00%	$	$ (1,872,167)	1
2	V	32	Interest	2,242	Jackson Square Associates	100.00%		(2,242)	2
3	V	30	Depreciation		Jackson Square Associates	100.00%	202,928	202,928	3
4	V	36	Amortization		Jackson Square Associates	100.00%	5,965	5,965	4
5	V	33	Real Estate Taxes		Jackson Square Associates	100.00%	314,054	314,054	5
6	V	36	MIP Expense		Jackson Square Associates	100.00%	119,036	119,036	6
7	V	32	Interest - HUD Loan		Jackson Square Associates	100.00%	665,374	665,374	7
8	V	26	Property & Liability Insurance		Jackson Square Associates	100.00%	7,286	7,286	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,874,409			$ 1,314,643	$ * (559,766)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 3,078	$ 3,078	15
16	V	6	REPAIRS AND MAINT.				4,258	4,258	16
17	V	17	ADMINISTRATIVE - NON-OWNER				22,628	22,628	17
18	V	19	PROFESSIONAL FEES				3,486	3,486	18
19	V	20	FEES SUBSCRIPTIONS				1,925	1,925	19
20	V	21	CLERICAL & GENERAL				164,986	164,986	20
21	V	24	SEMINARS AND EDUCATION				655	655	21
22	V	25	ADMIN. STAFF TRAVEL				418	418	22
23	V	26	INSURANCE				5,832	5,832	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.				28,808	28,808	24
25	V	30	DEPRECIATION				9,509	9,509	25
26	V	32	INTEREST EXPENSE				1,302	1,302	26
27	V	33	REAL ESTATE TAX				2,585	2,585	27
28	V	34	BUILDING RENT				515	515	28
29	V	35	EQUIPMENT RENTAL				3,566	3,566	29
30	V	17	ADMIN. - R. HARTMAN				4,723	4,723	30
31	V	17	ADMIN. - B. CARR				12,617	12,617	31
32	V	17	ADMIN. - D. HARTMAN						32
33	V	27	EMP. BEN. - R. HARTMAN				1,606	1,606	33
34	V	27	EMP. BEN. - B. CARR				858	858	34
35	V	27	EMP. BEN. - D. HARTMAN						35
36	V	17	MANAGEMENT FEES	779,442				(779,442)	36
37	V								37
38	V								38
39	Total			$ 779,442			$ 273,355	$ * (506,087)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workmans Compensation	$ 63,042	Diamond Insurance	40.00%	$ 63,042	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,042			$ 63,042	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	60.75%	See Attached	1.89	3.78%	Allocated	$ 4,723	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	4.72	9.44%	Allocated	12,617	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,340		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	904,250	11	$ 32,587	$	85,410	$ 3,078	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	904,250	11	45,083		85,410	4,258	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	904,250	11	239,568	232,849	85,410	22,628	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	904,250	11	36,902		85,410	3,486	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	904,250	11	20,379		85,410	1,925	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	904,250	11	1,746,738	1,454,049	85,410	164,986	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	904,250	11	6,935		85,410	655	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	904,250	11	4,428		85,410	418	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	904,250	11	61,742		85,410	5,832	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	904,250	11	304,996		85,410	28,808	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	904,250	11	100,669		85,410	9,509	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	904,250	11	13,784		85,410	1,302	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	904,250	11	27,371		85,410	2,585	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS	904,250	11	5,450		85,410	515	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	904,250	11	37,756		85,410	3,566	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	11	50,000	50,000	2	4,723	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED	50	11	133,580	133,580	5	12,617	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	40	2	4,069	4,069			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	11	17,006		2	1,606	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	50	11	9,079		5	858	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	40	2	4,925				21
22										22
23										23
24										24
25	TOTALS					$ 2,903,047	$ 1,874,548		$ 273,355	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd. Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation			$	$		$ 63,042	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 63,042	25

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$ 12,931,281			$ 665,374	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholders		X					600,000		Annual	63,335	6
7	Alloc - Nucare Services Corp		X								1,302	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 13,531,281			$ 730,011	9
	B. Non-Facility Related*											
10	Int Inc - Jackson Associate		X								(2,242)	10
11	Interest Income										(15)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (2,257)	14
15	TOTALS (line 9+line14)						$	$ 13,531,281			$ 727,754	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 119,306 Line # 36

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	311,107	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	280,893	2
3. Under or (over) accrual (line 2 minus line 1).	$	(30,214)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	317,148	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5,841	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 22,528 For 95,96,02 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	292,775	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	322,703	8
2001	331,096	9
2002	334,808	10
2003	295,482	11
2004	278,308	12

2005 Accrual = $302,046 x 1.05 = $317,148

Allocation from Nucare = $2,585

Refunds are not adjusted since they pertain to tax years which were not used to set a rate.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-209-002-0000	Long Term Care	$ 302,045.89	$ 278,307.89
2.	10-27-319-028-0000	Allocated - Nucare Service	$ 91,772.00	$ 2,172.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 393,817.89	$ 280,480.15

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medical Clinic - Costs are not included on Page 3-4.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	89,364	1987	$ 71,619	1
2	Alloc - 7257			7,357	2
3	TOTALS	89,364		$ 78,976	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	198,972		20	9,949	9,949	49,744	9
10	Various			1988	17,097		20	854	854	4,274	10
11	Various			1989	19,023		20	952	952	4,757	11
12	Various			1990	33,869		20	1,693	1,693	8,467	12
13	Various			1991	10,518		20	526	526	2,630	13
14	Various			1993	3,315		20	166	166	829	14
15	Various			1994	110,244		20	5,512	5,512	29,572	15
16	Various			1995	57,890		20	2,896	2,896	30,477	16
17	Various			1996	131,988		20	6,601	6,601	62,719	17
18	Various			1997	126,299		20	6,411	6,411	53,523	18
19	Various			1998	35,115		20	1,756	1,756	13,219	19
20	Various			1999	67,125		20	3,359	3,359	21,821	20
21	Various			2000	182,497		20	9,126	9,126	53,837	21
22	Various			2001	24,742		20	1,237	1,237	5,629	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,173,042	202,928		95,250	(107,678)	1,619,667	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		98,463	4,413		3,320	(1,093)	6,339	68
69	Financial Statement Depreciation			165,915			(165,915)		69
70	TOTAL (lines 4 thru 69)		$ 4,290,199	$ 373,256		$ 149,608	$ (223,648)	$ 1,967,504	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,290,199	$ 373,256		$ 149,608	$ (223,648)	$ 1,967,504	1
2	Replace Boiler	2002	3,975		20	397	397	1,590	2
3	Exit Signs On 3Rd And 4Th Fl.	2002	1,537		20	154	154	615	3
4	Closed Circuit Tv System	2002	1,407		20	141	141	563	4
5	Alarm System (Serv/Upgrade)	2002	1,358		20	136	136	543	5
6	Install Magenetic Door Holders	2002	1,424		20	142	142	546	6
7	Install Closed Circ. Tv Sys.	2002	1,418		20	142	142	544	7
8	Install Alarm System	2002	1,334		20	133	133	478	8
9	Closed Circuit Tv System	2002	4,186		20	419	419	1,500	9
10	Installed Glass And Skylight	2002	1,795		20	180	180	658	10
11	115 Volt Fan	2002	980		20	98	98	335	11
12	Inside Awnings	2002	1,117		20	112	112	372	12
13	Awning For Back Door/Patio	2002	2,025		20	203	203	675	13
14	Landscaping	2002	14,800		20	1,480	1,480	4,933	14
15	Cctv System	2002	2,858		20	286	286	976	15
16	Cctv System	2002	1,953		20	195	195	667	16
17	Cctv System	2002	1,706		20	171	171	569	17
18	Supplies To Install Overbed Lights	2002	914		20	91	91	297	18
19	Cctv System Recorder	2002	1,410		20	141	141	458	19
20	78 Overbed Light Fixtures	2002	5,616		20	562	562	1,825	20
21	Installed Elctromagnet Door Holders	2002	1,446		20	145	145	458	21
22	Service On Cctv	2002	1,298		20	130	130	411	22
23	Additional Trip Charges	2002	2,300		20	230	230	767	23
24	20 Overbed Light Fixtures	2002	1,440		20	144	144	444	24
25	Service On Cctv	2002	1,106		20	111	111	442	25
26	Service On Cctv	2002	910		20	91	91	364	26
27	Resurface Pk Lot/Sidewalk	2002	34,263		20	3,426	3,426	11,421	27
28	Saftey Lock System	2002	405		20	41	41	135	28
29	Woodwork, Remodeling	2002	23,200		20	2,320	2,320	9,280	29
30	Outdoor Signs	2003	6,000		20	600	600	1,800	30
31	Outdoor Signs	2003	11,627		20	1,163	1,163	3,488	31
32	Cctv	2003	1,684		20	168	168	463	32
33	Dr Alarm	2003	886		20	127	127	348	33
34	TOTAL (lines 1 thru 33)		$ 4,428,577	$ 373,256		$ 163,487	$ (209,769)	$ 2,015,469	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,428,577	$ 373,256		$ 163,487	$ (209,769)	$ 2,015,469	1
2	Tel Lines	2003	1,064		20	106	106	293	2
3	Elevator Repair	2003	6,276		20	314	314	837	3
4	Wall Paper	2003	1,008		20			1,008	4
5	Tel Lines	2003	999		20	100	100	258	5
6	Tel Lines	2003	873		20	87	87	226	6
7	Fire Alarm	2003	858		20	123	123	317	7
8	Tel Lines	2003	1,075		20	108	108	278	8
9	Install Tel	2003	629		20	63	63	162	9
10	Install Telephone	2003	977		20	98	98	252	10
11	Drapery	2003	1,586		20	159	159	423	11
12	Conc Drive	2003	14,371		20	1,437	1,437	3,713	12
13	Land Improvement	2003	740		20	49	49	123	13
14	Limestone Planters	2003	5,960		20	397	397	1,026	14
15	Landscape	2003	2,291		20	153	153	382	15
16	Carpet	2003	2,414		20	345	345	805	16
17	New Sign	2003	999		20	100	100	216	17
18	Window Treatment	2003	399		20	40	40	90	18
19	Lights	2003	1,522		20	152	152	330	19
20	Vinal Tile	2003	739		20	49	49	103	20
21	Fire Alarm	2003	1,196		20	171	171	370	21
22	Nurse Station	2003	9,500		20	950	950	2,454	22
23	Medical Room	2003	2,900		20	290	290	749	23
24	Medical Room - Fl4	2003	2,900		20	290	290	749	24
25	Locksets	2003	1,073		20	107	107	286	25
26	Locksets	2003	233		20	23	23	62	26
27	Waste Water Disposal	2003	1,569		20	157	157	418	27
28	Glass Installation	2003	705		20	71	71	182	28
29	Locks	2003	769		20	77	77	186	29
30	Toilets	2003	531		20	53	53	111	30
31	Faucets	2003	519		20	52	52	134	31
32	Boiler Repairs	2003	1,088		20	91	91	272	32
33	Motor	2003	710		20	71	71	189	33
34	TOTAL (lines 1 thru 33)		$ 4,497,050	$ 373,256		$ 169,770	$ (203,486)	$ 2,032,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,497,050	$ 373,256		$ 169,770	$ (203,486)	$ 2,032,473	1
2	Pump Motor	2003	824		20	82	82	185	2
3	Elevator	2003	534		20	27	27	58	3
4	Corner Guards	2003	527		20	53	53	123	4
5	Thermal Expansion Tank	2003	583		20	58	58	175	5
6	Hot Water Heater	2003	11,795		20	1,180	1,180	3,539	6
7	Wiring, Electric Work	2003	861		20	86	86	179	7
8	Wiring, Electric Work	2003	971		20	97	97	202	8
9	Wiring, Electric Work	2003	1,572		20	157	157	328	9
10	Wiring, Electric Work	2003	1,440		20	144	144	300	10
11	Wiring, Electric Work	2003	1,105		20	111	111	230	11
12	Submersible Pump	2004	1,249		20	125	125	250	12
13	Wiring For Printers	2004	724		20	72	72	133	13
14	Telephone Lines	2004	1,151		20	115	115	201	14
15	Nurses Station Service	2004	1,141		20	76	76	127	15
16	Front Door Locking System	2004	542		20	77	77	129	16
17	Telephone System Service	2004	1,036		20	104	104	147	17
18	Table Top	2004	1,200		20	120	120	170	18
19	Alarm Service On Doors	2004	1,502		20	215	215	286	19
20	Video Recorder Monitor System	2004	1,766		20	252	252	336	20
21	Data Cables	2004	1,223		20	122	122	153	21
22	Control Panel	2004	865		20	58	58	72	22
23	Extending Vents	2004	1,255		20	126	126	157	23
24	Ceiling Fixtures, Monitoring System	2004	873		20	87	87	102	24
25	Front Door Locking System	2004	869		20	124	124	145	25
26	Paging System	2004	3,293		20	470	470	510	26
27	Activity Room Signs	2004	886		20	89	89	111	27
28	Replace Glass In Resident Rooms	2004	575		20	58	58	115	28
29	Polished Wire Glass/Safety Galss	2004	725		20	73	73	145	29
30	Replace Glass In Resident Rooms	2004	620		20	62	62	124	30
31	Light Fixtures	2005	1,190		20	119	119	119	31
32	Light Fixtures	2005	1,190		20	119	119	119	32
33	Light Fixtures	2005	1,233		20	123	123	123	33
34	TOTAL (lines 1 thru 33)		$ 4,542,370	$ 373,256		$ 174,551	$ (198,705)	$ 2,041,566	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,542,370	$ 373,256		$ 174,551	$ (198,705)	$ 2,041,566	1
2	Light Fixtures	2005	808		20	67	67	67	2
3	Light Fixtures	2005	1,133		20	85	85	85	3
4	Light Fixtures	2005	850		20	50	50	50	4
5	Light Fixtures	2005	1,133		20	66	66	66	5
6	Light Fixtures	2005	1,180		20	89	89	89	6
7	Block Heater On Generator	2005	1,327		20	111	111	111	7
8	Ceiling Tiles	2005	650		20	22	22	22	8
9	Ceiling Tiles	2005	28,859		20	601	601	601	9
10	Wallpaper	2005	850		20	283	283	283	10
11	Barber Shop Cabinets, Mirrors	2005	7,700		20	513	513	513	11
12	Sprinker System	2005	6,750		20	281	281	281	12
13	Landscaping	2005	15,421		20	343	343	343	13
14	Ceiling Tiles	2005	650		20	14	14	14	14
15	Light Fixtures	2005	1,416		20	47	47	47	15
16	Patio Cover	2005	6,840		20	114	114	114	16
17	Plumbing Fixtures	2005	1,117		20	12	12	12	17
18	Horizontal Heat Pump	2005	2,593		20	43	43	43	18
19	Elevator Work	2005	71,890		20	599	599	599	19
20	Wallpaper	2005	844		20	211	211	211	20
21	Floor Tile	2005	731		20	12	12	12	21
22	Window Treatment	2005	1,058		20	18	18	18	22
23	Fire System Repairs	2005	829		20	28	28	28	23
24	Limp	2005	13,934		20	664	664	664	24
25	Plumbing Fixtures	2005	350		20	4	4	4	25
26	Light Fixtures	2005	2,214		20	37	37	37	26
27	Ceiling Tiles	2005	665		20	8	8	8	27
28	Counters, Cabinets, Desks	2005	30,000		20	1,500	1,500	1,500	28
29	Elevator Work	2005	10,000		20	42	42	42	29
30	Carpeting	2005	2,823		20	34	34	34	30
31	Cubicle Curtains	2005	1,055		20	9	9	9	31
32	Floor Tiles	2005	953		20	16	16	16	32
33	Eqip	2005	913		20	10	10	10	33
34	TOTAL (lines 1 thru 33)		$ 4,759,906	$ 373,256		$ 180,484	$ (192,772)	$ 2,047,499	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,759,906	$ 373,256		$ 180,484	$ (192,772)	$ 2,047,499	1
2	Floor Tile	2005	1,484		20	16	16	16	2
3	Tile Flooring	2005	427		20	5	5	5	3
4	Floor Tiling	2005	199		20	1	1	1	4
5	Floor Tiling	2005	1,647		20	9	9	9	5
6	Wallpaper	2005	805		20	268	268	268	6
7	Boiler	2005	5,364		20	447	447	447	7
8	Water Pump	2005	3,246		20	216	216	216	8
9	Cabling And Phone Upgrades	2005	16,403		20	137	137	137	9
10	Plumbing Work	2005	678		20	62	62	62	10
11	Generator Work	2005	1,248		20	104	104	104	11
12	Data Cables	2005	1,040		20	61	61	61	12
13	Fire System Work	2005	1,670		20	139	139	139	13
14	Data Lines	2005	825		20	21	21	21	14
15	Ceiling Tiles	2005	665		20	3	3	3	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	1
2									2
3									3
4									4
5									5
6									6
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8									8
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10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,795,607	$ 373,256		$ 181,973	$ (191,283)	$ 2,048,988	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1987	1980	$ 3,173,042	$ 202,928		$ 95,250	$ (107,678)	$ 1,619,667	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
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31											31
32											32
33											33
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,173,042	$ 202,928		$ 95,250	$ (107,678)	$ 1,619,667	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated - 7257 N. Lincoln Avenue, LLC		2004	2004	$ 66,211	$ 1,698	35	$ 1,892	$ 194	$ 4,020	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated - Nucare Services Corp.			2003	1,106	55	20	55		117	9
10	Allocated - Nucare Services Corp.			2004	22,462	1,123	20	1,123		1,919	10
11	Allocated - Nucare Services Corp.			2005	1,332	371	20	33	(338)	33	11
12											12
13	Allocated - 7257 N. Lincoln Avenue, LLC			2004	1,316	745	20	66	(679)	99	13
14	Allocated - 7257 N. Lincoln Avenue, LLC			2005	6,036	421	20	151	(270)	151	14
15											15
16											16
17											17
18											18
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 98,463	$ 4,413		$ 3,320	$ (1,093)	$ 6,339	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 930,543	$ 4,259	$ 115,066	$ 110,807	10	$ 530,362	71
72	Current Year Purchases	77,088	837	4,312	3,475	10	4,562	72
73	Fully Depreciated Assets	24,507				10	24,507	73
74								74
75	TOTALS	$ 1,032,138	$ 5,096	$ 119,378	$ 114,282		$ 559,431	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	$ 2,282	$	$	$	5	$	76
77										77
78										78
79										79
80	TOTALS			$ 2,282	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,909,003	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 378,352	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 301,351	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (77,001)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,608,419	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	INSTALL NEW COMPRESS - 2000	$ 16,764	$ 838	$	86
87	WATER FAUCETS - 2001	1,361	68		87
88	RESURFACE PK LOT/SIDEWALK - 20(	2,778	278		88
89					89
90					90
91	TOTALS	$ 20,903	$ 1,184	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 12,213 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	2001 Lexus RX300	$ 593.00	$ 1,779	17
18					18
19					19
20					20
21	TOTAL		$ 593.00	$ 1,779	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 337,514	$		$ 337,514	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			193,744			193,744	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			210,701	29,078		239,779	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					1,041		1,041	12
13	Other (specify): See Supplemental			3,880		370	55,558		59,808	13
14	TOTAL			$ 3,880		$ 742,329	$ 85,677		$ 831,886	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,386	$ 266,571	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,882,429	1,947,471	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	189,925	248,783	6
7	Other Prepaid Expenses	15,037	15,037	7
8	Accounts Receivable (owners or related parties)	380,349	380,349	8
9	Other(specify): See Attached Schedule	13,219	769,651	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,484,345	$ 3,627,862	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		888,457	13
14	Buildings, at Historical Cost		3,333,738	14
15	Leasehold Improvements, at Historical Cost	1,174,764	5,599,184	15
16	Equipment, at Historical Cost	897,158	1,395,798	16
17	Accumulated Depreciation (book methods)	(1,140,346)	(4,112,842)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		201,333	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	54,080	54,080	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 985,656	$ 7,359,748	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,470,001	$ 10,987,610	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 569,678	$ 569,828	26
27	Officer's Accounts Payable		198,244	27
28	Accounts Payable-Patient Deposits	(815)	(815)	28
29	Short-Term Notes Payable	600,000	600,000	29
30	Accrued Salaries Payable	308,457	308,457	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,350	15,350	31
32	Accrued Real Estate Taxes(Sch.IX-B)		317,148	32
33	Accrued Interest Payable		55,173	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,100	20,100	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	216,014	216,014	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,728,784	$ 2,299,499	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,931,281	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,931,281	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,728,784	$ 15,230,780	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,741,217	$ (4,243,170)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,470,001	$ 10,987,610	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,856,353	1
2	Restatements (describe):		2
3	MANAGEMENT FEES	(57,900)	3
4	VACATION PAY	30,948	4
5	BAD DEBTS	93,521	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,922,922	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(181,705)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (181,705)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,741,217	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,292,495	1
2	Discounts and Allowances for all Levels	(252,267)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,040,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,135,003	6
7	Oxygen	1,473	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,136,476	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	118,500	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,064	19
20	Radiology and X-Ray	5,958	20
21	Other Medical Services	558,325	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 721,847	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,898,566	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,785,079	31
32	Health Care	3,438,391	32
33	General Administration	2,722,630	33
	B. Capital Expense		
34	Ownership	2,105,361	34
	C. Ancillary Expense		
35	Special Cost Centers	900,695	35
36	Provider Participation Fee	128,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,080,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	(181,705)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (181,705)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,959	2,154	$ 94,908	$ 44.06	1
2	Assistant Director of Nursing	796	885	33,583	37.95	2
3	Registered Nurses	9,254	10,056	367,242	36.52	3
4	Licensed Practical Nurses	44,907	48,296	1,029,568	21.32	4
5	CNAs & Orderlies	108,228	119,150	1,143,077	9.59	5
6	CNA Trainees					6
7	Licensed Therapist	167	167	3,880	23.23	7
8	Rehab/Therapy Aides	1,011	1,011	10,080	9.97	8
9	Activity Director	1,949	2,086	29,910	14.34	9
10	Activity Assistants	5,265	5,949	60,191	10.12	10
11	Social Service Workers	3,643	4,142	111,574	26.94	11
12	Dietician	3,528	3,864	63,511	16.44	12
13	Food Service Supervisor					13
14	Head Cook	4,900	5,400	48,870	9.05	14
15	Cook Helpers/Assistants	20,646	22,292	181,714	8.15	15
16	Dishwashers					16
17	Maintenance Workers	10,483	5,880	94,566	16.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,102	2,514	43,447	17.28	20
21	Assistant Administrator					21
22	Other Administrative	1,036	1,036	67,507	65.16	22
23	Office Manager					23
24	Clerical	20,623	22,337	213,357	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,817	4,218	102,775	24.37	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	7,435	8,244	195,245	23.68	33
34	TOTAL (lines 1 - 33)	251,749	269,681	$ 3,895,005 *	$ 14.44	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,520	01-03	35
36	Medical Director	Monthly	21,600	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	5,413	10-03	38
39	Pharmacist Consultant	Monthly	3,712	10-03	39
40	Physical Therapy Consultant	Monthly	2,677	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,370	11-03	44
45	Social Service Consultant	22	1,170	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	$ 51,686		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	46	$ 2,794	10-03	50
51	Licensed Practical Nurses	1,524	50,302	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,570	$ 53,096		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Celerio	Administrator	0	$ 14,074
Farhat Sharif	Administrator	0	29,373
Kathleen Brander	Dir Reg Mgmt	0	13,521
Marilyn Flaherty	VP of Medicare	0	15,707
Jennifer Bebinger	Alz Unit Dir	0	14,188
Gerry Jenich	CEO	0	24,090
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,953

B. Administrative - Other

Description	Amount
Nucare Services Corp - Management Fees	$ 779,422
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 779,422

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting Fees	$ 23,942
Giftrap Solutions	Computer Service	4,260
HDSI	Computer Service	7,736
Ivans	Computer	1,226
Personnel Planners	Unemployment Consultant	5,581
CDW	Computer Service	1,315
Medifax	Computer Service	1,063
PSD Solutions	Computer	7,535
Purchasing Plus	Purchases Consultants	450
Emdeon Business Service	Computer Service	448
Charles Ross	Marketing (Adj out on Page 5)	4,078
See Supplemetal Schedule		34,878
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 92,512

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,042
Unemployment Compensation Insurance	63,258
FICA Taxes	293,139
Employee Health Insurance	137,219
Employee Meals	16,983
Illinois Municipal Retirement Fund (IMRF)*	
Pension	30,834
Dental Insurance	4,551
401K Matching	6,458
Chicago Head Tax	6,672
Employee Benefits	20,693
TOTAL (agree to Schedule V, line 22, col.8)	$ 642,849

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	42,876
Health Care Worker Background Check	1,000
(Indicate # of checks performed 83)	
Subscriptions	1,218
Il Council Dues	12,671
Dues	625
Licenses and Fees	6,331
See Supplemental Schedule	66,311
Less: Public Relations Expense	( )
Non-allowable advertising	(64,062)
Yellow page advertising	(284)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,686

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,208
Alloc - Nucare Services Corp	655
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,863

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab Ctr # 0039834 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $12,671**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,975** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **128,115**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,983** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% in 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.